RBRVS: Still good news for physicians

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Lately, many physicians have been saying they've become disillusioned with the RBRVS. They don't believe the physician payment reform will bring gains for their undervalued evaluation and management services. They don't trust the federal government to live up to its end of the bargain. However, no one should write off the RBRVS. As can be seen from the text below, RBRVS will protect undervalued evaluation and management services in an era of medicare budget-cutting; it will *introduce fairness and rationality into the Medicare payment system; it* will *provide a basis for arguing against unfair cuts in reimbursement (such as the recent ban on payment for most EKG interpretations) and it* will *bring the profession together to fight against any further cuts in the Medicare program.*

When the Resource-Based Relative Value Scale first came onto the health policy scene, physicians supported it because it would introduce fairness and rationality into the Medicare payment system, unite the medical profession, and, most of all, because it would be good for patients. But lately, I've been hearing many of my colleagues say they've become disillusioned with the RBRVS's implementation — they don't trust the federal government to live up to its end of the bargain.

Well, I don't trust the federal government to live up to its bargain, either — at least not without concentrated pressure on it to do so. However, I don't think the medical profession should write off the RBRVS. Despite many problems — some immediate and some potential — it still will do what it was intended to do.

For instance, under the RBRVS, relative values are expected to increase substantially for most evaluation and management (E/M) services. Skeptics have suggested that the RBRVS will be used only to cut surgical values — and fees. New estimates show, however, that the RBRVS will increase relative values for E/M services by 30% on average, and that, as a result, Medicare payments for these services will increase substantially above 1991 payments under a "budget neutral" RBRVS fee schedule.

Better yet, the RBRVS protects undervalued evaluation and management services provided by all physicians *even when the budget is cut.* Consider what would happen to a $30 office visit from 1991 to 1996 in a purely hypothetical scenario in which fees normally would have been given a 15% inflation increase, but Congress cuts payments 10% below inflation. In 1996, that same office visit fee would total $31.05 without the RBRVS. With the protected 30% gain for E/M services expected under the RBRVS, it would total $40.36. Especially in this budget-cutting climate, the RBRVS will protect fees for the E/M services *all* physicians provide.

Exactly what effect there will be on an individual's practice depends on several factors, however. Because of elimination of geographic differentials and limits on balance billing, for some there will be no actual gain (or even a reduction) for E/M services. Where physicians practice, how often they accept assignment, how much they charge in excess of Medicare's "approved amount" for unassigned claims, and their mix of services, will determine the effect on their practices. *But regardless of each individual's gain or loss, the RBRVS will enhance payments overall for physicians' E/M services compared with what would have been.*

Another benefit is that the RBRVS allows physicians to unite for a fair conversion factor and to oppose further cuts in the Medicare program, rather than engaging in internal squabbling. The conversion factor that makes the RBRVS into a real fee schedule applies to *all* physician services. That means the entire profession has a stake in making sure it's fair and an incentive to work *together* to stave off future Medicare cuts. In fact, every medical group that testified before the Physician Payment Review Commission (PPRC) last December, including the American Medical Association, the American Society of Internal Medicine, the American Academy of Family Physicians and the American College of Surgeons, opposed HCFA's proposal to lower the conversion factor. HCFA has indicated it will assume volume will increase and that it will set the conversion factor lower to make up for that assumed increase.

The RBRVS also provides a basis for opposing unfair cuts in specific procedures. For example, the profession can argue that the ban on reimbursement for most EKG interpretation is contrary to the RBRVS, because the study said the service indeed has a value. The influential PPRC agrees, giving the profession a real opportunity to get this cut reversed. Without the RBRVS, it would have been far more difficult to make that case.

Continued support for the RBRVS allows the profession to be *for* — not just against — something. If it wasn't for the medical profession's support for the RBRVS, we'd all be

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Indications and Techniques. Menlo Park: Addison-Wesley Publishing, 1982: 383-413.
15. Sanchez-Craig M: Level of Alcohol Use for the Onset of Early-Stage Problem Drinking. In: Chang NC, Chao HM, eds. Early Identification of Alcohol Abuse, Proceeding of a Workship sponsored by the National Institute on Alcohol Abuse and Alcoholism in Cooperation with the World Health Organization and the Pan American Health Organization. 1985:339-347.
16. Yersin B, Trisconi Y, Paccaud F, et al: Accuracy of the Michigan Alcoholism Screening Test for Screening of Alcoholism in Patients of a Medical Department. *Arch Intern Med* 1989;149:2071-2074.
17. Cleary PD, Miller M, Bush BT, et al: Prevalence and Recognition of Alcohol Abuse in a Primary Care Population. *Am J Med* 1988;85:466-471.
18. Moore RD, Bone LR, Geller G, et al: Prevalence, Detection, and Treatment of Alcoholism in Hospitalized Patients. *JAMA* 1989;261:403-407.
19. Cyr MG, Wartman SA: The Effectiveness of Routine Screening Questions in the Detection of Alcoholism. *JAMA* 1988;259: 51-54.
20. Coulehan JL, Zettler-Segal M, et. al.: Recognition of Alcoholism and Substance Abuse in Primary Care Patients. *Arch Intern Med* 1987;147:349-352.
21. Lee DJ, DeFrank RS: Interrelationships Among Self-Reported Alcohol Intake, Physiological Indices and Alcoholism Screening Measures. *J Stud Alcohol* 1988;49:532-537.

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worse off. No one can say that change won't be coming. Those who don't like the RBRVS and the limits on balance billing should consider the alternatives: mandatory assignment, MD-DRGs, and fees set by the government without any professional input. The RBRVS gives the profession a voice, and it enables us to ward off more objectionable measures.

Finally and most importantly, *the RBRVS is good for our patients.* It will increase the emphasis on preventive care and on evaluating and managing their treatment, and decrease the emphasis on costly high-tech services. It also will help improve access to care in underserved rural areas.

So you see, to paraphrase Mark Twain, reports of the death of the RBRVS are greatly exaggerated. But medicine can't rely on trust that everything will turn out okay. We must fight to preserve the promise of physician payment reform.

That means opposing policies that will undermine the RBRVS (such as a behavioral assumption that would lower the fee schedule conversion factor). It means working to change policies — such as the ban on reimbursement for EKG interpretation — that give with one hand and take away with the other. And it means supporting further changes that will make the system even better.

The RBRVS unites physicians under one fair and rational payment system to fight future detrimental budget cuts in Medicare. Lawmakers faced with a divided house of medicine easily can use that division to cut Medicare payments even further. But if they're faced with a profession that's united under the RBRVS, it won't be easy.

Support for the RBRVS has been right — for our profession and for our patients. The RBRVS will protect undervalued evaluation and management services in an era of Medicare budget cutting, increase access and the emphasis on preventive care for patients, and introduce fairness into the Medicare payment system. *But we must fight together — as a profession — to make sure it is implemented in the way Congress intended.*

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